Administrative Office: 2801 Devine Street, Columbia, South Carolina 29205
(herein called American General)
800-308-6457

GROUP SPECIFIED CRITICAL ILLNESS POLICY
Based on the application for this Group Insurance Policy (herein called the Plan) made by

STATE PERSONNEL ADMINISTRATION

(herein called the Policyholder)
and based on the payment of the premium when due, American General agrees to pay the benefits provided on the following pages.

THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY. PLEASE READ THE POLICY CAREFULLY
If an Insured is eligible for Medicare, review the Guide to Health Insurance For People with Medicare.

This Plan becomes effective at 12:01 a.m. Standard Time at the policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by American General on the following pages forms a part of this Plan as if recited over the signature below. This Plan is a legal contract between American General and the policyholder.

This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof American General has caused this Plan to be executed at its Administrative Office in Columbia, South Carolina on the Effective Date.

READ THIS POLICY CAREFULLY.
Signed for the Company

President

Countersigned by

_____
Licensed Resident Agent (if required by the state)

Group Policy Number	- 8682		
Effective Date	- July 1, 2005	**Anniversary Date**	- July 1, 2006
Jurisdiction	- Georgia	**Non-Participating**	

GROUP POLICY PROVISIONS

SECTION I ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

An employee is eligible if he is:

1. eligible to participate in the Flexible Benefits Program as follows:

   (a) Regular full-time employees of the State of Georgia or of a state agency who work at least 30 hours a week on a continuing basis and whose employment is expected to last at least nine (9) months;

   (b) Public school teachers who are employed in a professionally certificated capacity, work half-time (50%) or more, and at least seventeen and one-half (17.5) hours per week, and are not considered "temporary" or "emergency" employees;

   (c) Employees of a local school system who hold a non-certificated position, are eligible to participate in the Teachers' Retirement System or its equivalent, and work at least twenty (20) hours per week; or 60% of the time normally required for these positions, if that is more than 20 hours per week;

   (d) Employees who are eligible to participate in the Public School Employees' Retirement System and work at least fifteen (15) hours per week or 60% of the time normally required for these positions, if that is more than 15 hours per week;

   (e) Employees of a county or regional library who works at least seventeen and one-half (17.5) hours per week;

   (f) Employees who are in active employment and a member of the General Assembly, a constitutional officer, or an employee of an appropriate judicial branch;

   (g) Other employees deemed eligible by Federal and State of Georgia law.

2. at least 18 years of age and under age 70 at initial eligibility date; and

3. actively at work.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for an Employee is as follows:

1. An Employee's insurance will be effective on the date shown on the Certificate Schedule provided the Employee is then actively at work.

3. If an Employee is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Employee is first thereafter actively at work.

An eligible employee may enroll for coverage or change multiples of coverage during the Open Enrollment period.
An eligible employee may also enroll or increase coverage within thirty (30) days of a change in status event.
An employee may decrease or terminate coverage within thirty (30) days of a change in status event.

If an employee enrolls for coverage or increases coverage above the guarantee issue due to a change in status event, proof of medical insurability is required. The employee should ask the Plan Administrator for the effective date for a change in coverage due to a change in status event.

Changes must be consistent with the change in status event.

If the employee ends employment and is rehired within the same plan year, the employee may be insured on his/her eligibility date for the coverage the employee had under the plan when the employee ended employment. The employee cannot change his coverage until the next annual Open Enrollment period or a change in status event.

LEAVE WITHOUT PAY AND PREMIUM PAYMENTS

Coverage is extended on a month-by-month basis. Premiums for coverage must be paid in advance of coverage. Normally, premiums are paid through payroll reduction/deduction in the month prior to coverage. When an employee is not in pay status, the employee must pay the monthly premium amount to the Flexible Benefits Program prior to the first of each coverage month.

If you cease to be Actively at Work due to:

- suspension without pay, or
- approved leave of absence without pay with respect to which you have a scheduled date of return,

your insurance may be continued through the twelfth (12^{th}) calendar month through personal premium payments. The exception to this rule is those employees affected by USERRA, who may continue personal premium payments as long as on active duty.

If you are absent from work without pay for any reason, discuss continuing your insurance with your personnel officer. If you coverage is terminated for failure to pay premium, your re-enrollment will be in accordance with the regulations of the Employee Benefit Plan Council and may include submitting new proof of insurability.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the grace period.

Forty-two months after the Plan Effective Date, American General has the right to cancel the Plan on the day prior to the date any premium is due by giving 60 days written notice.

The Plan will terminate when the number of participating Employees is less than the number mutually agreed upon by the policyholder and American General in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the policyholder's address. This will be without prejudice to the rights of any Employee as respects any claim arising during the period the Plan is in force.

The policyholder has the sole responsibility to notify Employees of such termination.

TERMINATION OF AN INSURED'S INSURANCE

An Insured's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 61st day after the premium due date if the required premium has not been paid;
3. on the date the Insured ceases to meet the definition of an Employee as defined in the Plan;

4. on the date he is no longer a member of the class eligible; or
5. on the premium due date following the date an Insured notifies the policyholder in writing.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance on Employees will be calculated in accordance with the Schedule of Premiums. The rates shown in the Schedule of Premiums are guaranteed for 42 months after the Effective Date of this Plan. After the guaranteed period they can be changed annually. American General will give the policyholder written notice 60 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

The first premiums are due on the Effective Date of this Plan. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan are to be paid to American General at our Administrative Office at 2801 Devine Street, Columbia, South Carolina, 29205. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 60-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 60 days. During the grace period, the Plan will stay in force, unless the policyholder has given American General written notice of discontinuance of the plan.

SECTION III DEFINITIONS

When the terms below are used in this Plan, the following definitions will apply:

Actively at Work - to be considered actively at work, an Insured must perform for a full normal workday the regular duties of his employment at the regular place of business of his employer or at a location to which he may be required to travel to perform the regular duties of his employment.

Covered Loss means that as a result of a covered specified critical illness an Insured's is hospital confined and incurs charges for room, board and other charges associated with that confinement.

Date of Diagnosis is:

For cancer and/or carcinoma in situ: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For stroke: The date a stroke occurred based on documented neurological deficits and neuroimaging studies.

For end stage renal failure: The date an Insured's doctor recommends that he begin renal dialysis.

Major organ transplant surgery or coronary artery bypass surgery: The date the surgery occurs for covered transplants or covered coronary artery bypass surgery.

Doctor means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include the Insured or a member of his family.

Family Member means the Insured's spouse, son, daughter, mother, father, sister, or brother.

Insured means an employee of the State of Georgia.

Open Enrollment means a period designated by the State Personnel Administration during which employees have the opportunity to enroll or change coverage.

Pathologist means a doctor, other than the Insured's or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Hospital - means a place which:

1. is legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. is supervised by a doctor;
4. has full-time nurses supervised by a registered nurse;
5. has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities; and
6. maintains permanent medical history records.

A Hospital is not:

1. a nursing home;
2. an extended care facility;
3. a convalescent home;
4. a rest home or a home for the aged;
5. a place for alcoholics or drug addicts; or
6. a mental institution.

Specified Critical Illness means such critical illness as shown in the Schedule and as defined in this Plan.

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

SPECIFIED CRITICAL ILLNESS DEFINITIONS

Cancer - means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Under this definition Cancer does not include:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasion);
3. Any skin cancers except melanomas;
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
5. Basal cell carcinoma and squamous cell carcinoma of the skin; and
6. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer which meets the diagnosis criteria of malignancy established by The American or Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Carcinoma in situ - means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or carcinoma in situ must be diagnosed in one of two ways:

1. Pathological Diagnosis - A pathological diagnosis of cancer or carcinoma in situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American or Osteopathic Board of Pathology.

2. Clinical Diagnosis - A clinical diagnosis of cancer or carcinoma in situ is based on the study of symptoms.

We will pay benefits for a clinical diagnosis only if:

1. A pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. There is medical evidence to support the diagnosis; and
3. A doctor is treating an Insured for cancer and/or carcinoma in situ.

Coronary Artery Bypass Surgery - means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant - means having a major organ transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infraction; and
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine physphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

Renal Failure (Kidney Failure) - means the end stage renal failure presenting as chronic, irreversible failure of both of an Insured's kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Stroke - means Apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the certificate date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke that produces permanent clinical neurological sequela persisting for at least 30 days following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

SECTION IV BENEFITS

We'll pay benefits if while his certificate is in force, an Insured is:

1. diagnosed with a Specified Critical Illness; and
2. confined to a hospital as a result of the Specified Critical Illness and charged for room, board and

other applicable charges.

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the specified critical illnesses shown on the Certificate Schedule if:

1. The Date of Diagnosis is while this Plan is in force;
2. The Insured is confined to a hospital as a result of the Specified Critical Illness and charged for room, board and other applicable charges; and
3. It is not excluded by name or specific description in this Plan.

The Insured's Initial Maximum Benefit amount is shown in the Certificate Schedule. If the Certificate Schedule shows a Maximum Benefit Reduction Date, the Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Certificate Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect when the hospitalization for specified critical illness begins.

We will figure the benefits for each Specified Critical Illness by multiplying:

1. The Maximum Benefit Amount (Initial or Reduced, as the case may be); TIMES

2. The Benefit Percentage shown in the "Benefit Percentages By Certificate Year" table in the Certificate Schedule for the applicable Specified Critical Illness and Certificate Year; LESS

3. Any partial benefits paid under that Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.

2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.

3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 12 months or 12 months treatment free for Cancer.

Partial Benefits

Partial Benefits will be paid for Carcinoma in-situ and Coronary Artery Bypass Surgery at the amount shown on the Certificate Schedule. Partial benefits will reduce the maximum benefits paid under the certificate by the amount paid as a partial benefit.

We figure partial benefits by multiplying:

1. The Insured's Maximum Benefit Amount (Initial or Reduced, as the case may be); LESS
2. Any benefits previously paid; TIMES
3. The Partial Benefit Percentage shown in the "Benefit Percentages By Certificate Year" table in the Certificate Schedule for the applicable Specified Critical Illness and certificate year.

Portability Privilege

When an Insured's coverage would otherwise terminate under this Plan because he ended employment with his Employer, he may elect to continue his coverage. But he must have been continuously insured for at least six

months under this Plan and/or the prior plan just before the date his employment terminated. The coverage an Insured may continue is that which he had on the date his employment terminated.

1. Coverage may not be continued for any of the following reasons:

   a. the insured failed to pay any required premium;
   b. the insured having attained age 70;
   c. this Plan terminates.

2. To keep his insurance in force the Insured must:

   a. make written application to the Company within 31 days after the date his insurance would otherwise terminate; and

   b. pay the required premium to the Company no later than 31 days after the date his insurance would otherwise terminate.

3. Insurance will cease on the earliest of these dates:

   a. the date the Insured failed to pay any required premium; or
   b. the date this Plan is terminated.

If the Insured qualifies for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in his certificate as previously issued will apply.

Health Screening Benefit (Calendar Year Limit)

We will pay this benefit for the following health screening tests performed while this Plan is in force. We will pay the amount shown in the Schedule for the following health screening tests. This benefit is payable once per calendar year up to the maximum benefit amount shown in the Schedule. Payment of this benefit will not reduce the face amount of a certificate.

Health Screening Test is defined as:

Stress test on a bicycle or treadmill,
Fasting blood glucose test,
Blood test for triglycerides,
Serum cholesterol test to determine level of HDL and LDL,
Bone marrow testing,
Breast ultrasound,
CA 15-3 (blood test for breast cancer),
CA 125 (blood test for ovarian cancer),
CEA (blood test for colon cancer),
Chest X-ray,
Colonoscopy,
Flexible sigmoidoscopy,
Hemocult stool analysis,
Mammography,
Pap smear,
PSA (blood test for prostate cancer),
Serum Protein Electrophoresis (blood test for myeloma),
Thermography.

There is no limit to the number of years an Insured can receive benefits for health screening tests, as long as this Plan and his certificate are in force.

We will pay this benefit regardless of the results of the test.

SECTION V LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

"Preexisting Condition" means a sickness or physical condition that, within the 12-month period prior to the Effective Date of an Insured's Certificate resulted in his receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12-months of the Effective Date of an Insured's Certificate which is caused by, contributed to, or resulting from a Preexisting Condition.

A claim for benefits for loss starting after 12-months from the Effective Date of an Insured's Certificate will not be reduced or denied on the grounds that it is caused by a Preexisting Condition.

A condition will no longer be considered preexisting at the end of 12 consecutive months starting and ending after the Effective Date of an Insured's Certificate.

"Treatment" means consultation, care or services provided by a doctor including diagnostic measures and taking prescribed drugs and medicines.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

SECTION VI CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within twenty (20) days after an Insured is confined to a hospital for the specified critical illness, or as soon as reasonably possible. The notice can be given to American General at our Administrative Office. Notice should include the name of the Insured and the Certificate number.

Claim Forms: When we receive a notice of claim, we will send the claimant forms for filing proof of loss. If the forms are not given to an Insured within 10 working days, he will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written proof of loss must be furnished to American General at our Administrative Office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of written proof of loss. Should American General fail to pay any benefits payable upon receipt of written proof of loss, we shall have 15 working days thereafter in which to notify the Insured in writing of the reasons why the claim has not been paid. The notice shall itemize the information needed to process the claim. When all information needed to process the claim is received, we then have 15 working days in which to either deny or pay the claim. If we fail to notify the Insured or pay the claim in the required time, we will pay interest equal to 18 percent per annum on the benefit due under this Plan.

Payment of Claims: All benefits will be payable to the Insured unless assigned by him or by operation of law. Any accrued benefit unpaid at an Insured's death may be paid to his estate.

Conformity with State Statutes: Any provision of this Plan which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

SECTION VII GENERAL PROVISIONS

Entire Contract, Changes: This policy together with the application, endorsements, benefit agreements, certificate and riders, if any, is the entire contract of insurance. No change in the policy shall be valid until approved in writing by an executive officer of American General. Any change must be noted on or attached hereto. No agent may change this policy or waive any of its provisions. Any rider, endorsement or application that modifies, limits or excludes coverage under this policy must be signed by the Insured, to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by an Insured in the application shall be used to void the coverage or to deny a claim for confinement to a hospital for a covered specified critical illness commencing after the expiration of such two-year period. (2) No claim for loss incurred after two years from the effective date of an Insured's coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such effective date.

Clerical Error: Clerical error by the policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Individual Certificate: American General will give the policyholder a certificate for each Employee. The certificate will set forth:

1. the coverage;
2. to whom benefits will be paid; and
3. the rights and privileges under the Plan.

Data Required: The policyholder will furnish all information and proofs that American General may reasonably require with regard to the Plan.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

SECTION VIII **BENEFIT SCHEDULE**

Initial Maximum Benefit Amount before age 70: See Certificate Schedules
Reduced Benefit Date: First Renewal Date after age 70
Reduced Maximum Benefit Amount: See Certificate Schedules
Percentage for Partial Benefits: 25%

SPECIFIED CRITICAL ILLNESS	BENEFIT PERCENTAGE BY CERTIFICATE YEAR	
	Certificate Year 1 - Age 70 Initial Maximum Benefit	After Age 70 Reduced Maximum Benefit
Stroke	100%	50%
Cancer	100%	50%
Kidney Failure	100%	50%
Heart Attack	100%	50%
Major Organ Transplant	100%	50%

PARTIAL BENEFITS

CANCER		
Carcinoma in situ	25%	12.5%

When this Partial Benefit is paid, it will reduce the cancer benefit by 25%.

HEART ATTACK		
Coronary Artery Bypass Surgery	25%	12.5%

When this Partial benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Health Screening Benefit Amount: up to $50 per insured per calendar year.

SECTION IX **SCHEDULE OF PREMIUMS**

Face Purchase – Monthly Premiums

Face	$ 5,000	$ 10,000	$ 20,000	$ 30,000	$ 40,000	$ 50,000
18-29	$ 3.78	$ 5.87	$ 10.04	$ 14.21	$ 18.38	$ 22.55
30-39	$ 5.58	$ 9.46	$ 17.22	$ 24.98	$ 32.74	$ 40.50
40-49	$ 10.23	$ 18.77	$ 35.84	$ 52.91	$ 69.99	$ 87.06
50-59	$ 16.83	$ 31.96	$ 62.23	$ 92.49	$ 122.75	$ 153.02
60-69	$ 25.95	$ 50.20	$ 98.70	$ 147.20	$ 195.70	$ 244.20

* Rates include benefits for the Cancer, Additional Occurrence, Re-occurrence, and Wellness Screening

Annual Rates

	Base Rate per $1,000	$50 Wellness Screening
18-29	$ 5.01	$ 20.37
30-39	$ 9.31	$ 20.37
40-49	$ 20.49	$ 20.37
50-59	$ 36.32	$ 20.37
60-69	$ 58.20	$ 20.37